☐ **High Dose** (65 yr & Over) ☐ **FluBlok** (50 yr & Over) ☐ **Fluzone** (6 mon & Over) ☐ **VFC Fluzone** (6 mon-18 yr) ☐ **317 Fluzone** (19 yr and older) ☐ **Flu Mist** (2 yr-49 yr)

Doniphan Co. Health Dept./Home Health
2026-2027 *Seasonal Flu* Vaccination Consent Form

Name: _____

Parent or guardian, if applicable**:** _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female Phone Number**:** _____

Mailing Address: _____ City: _____ Zip: _____

Race: ☐White ☐Alaskan Native/American Indian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Asian ☐Decline

Ethnicity: ☐Hispanic/Latino ☐ non-Hispanic ☐ Decline to Answer

Insurance*:*

☐ Private Insurance ☐ Medicare ☐ Medicaid (Sunflower, Healthy Blue, United) ☐ No Insurance ☐ Other _____

Policy Holder Name (if different from patient): _____

Primary Insurance: _____

Primary Insurance Number: _____

Immunization Screening Questionnaire:

1. Is the person to be vaccinated currently sick or experiencing high fever? ☐ **Yes** ☐ **No**

2. Does the person to be vaccinated have a history of Guillain Barre' Syndrome? ☐ **Yes** ☐ **No**
(A Syndrome in which the body damages its own nerve cells resulting in weakness and sometimes paralysis.)

3. Has the person to be vaccinated ever had a serious allergic reaction to eggs? ☐ **Yes** ☐ **No**

4. If the person receiving a flu shot is under 9 years of age, did he/she have the flu shot in the past? ☐ **Yes** ☐ **No** ☐ **NA**

5. Has the person to be vaccinated had a serious reaction to a previous dose of the flu vaccine? ☐ **Yes** ☐ **No**

6. Has the person to be vaccinated received any other vaccine in the last 4 weeks? ☐ **Yes** ☐ **No**

7. Does the person to be vaccinated have issues with asthma, wheezing, COPD, weakened immune system, CHF, chronic kidney problems, diabetes, egg allergy, or pregnant/breastfeeding? ☐ **Yes** ☐ **No**

I have been offered or provided, whether accepted or not, a copy of the "**Vaccine Information Statement(s)**and a Notice of Privacy Practices (NOPP) dated January 31, 2025." I have read, or have had explained to me, the information in the "Vaccine Information Statement(s)". My questions have been answered satisfactorily, and I ask that the flu vaccine be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

The Doniphan County Health Department/Home Health Agency ***can bill my insurance for any services rendered as applicable.*** I understand I ***will be responsible for any services provided which my insurance does not cover.*** ALL INFORMATION IS CONFIDENTIAL. I certify that the above information is correct to the best of my knowledge. I authorize the release of immunization records for the patient listed above to any licensed physician, primary care provider, local health department, educational institution, or regulated child/adult care facility. I understand any other health information for the patient listed above will not be released without written authorization from the patient's responsible party.

_____ _____

Signature of Patient or Parent/Guardian **Date**

PROVIDER INFORMATION							
Vaccine Provider: Doniphan Co. Health Dept./Home Health Agency			Clinic Site: DPCOHD		Charted	Submitted	
Street Address: 201. S. Main -PO Box 609, Troy	State KS	Zip Code 66087	Street Address: 201 S. Main Street, Troy	State KS	Zip Code 66087		

(Circle the appropriate vaccine, dose, extremity, site, route, and write in the manufacturer, lot #, and expiration date)

FOR CLINICAL USE ONLY								
Vaccine	**Dose**	**Ext.**	**Site**	**Route**	**VIS Date**		**Lot # and Exp Date**	
High Dose Tri	**0.5 mL** **1**	**RT** **LT**	Deltoid	IM	1/31/25			
FluBlok Tri	**0.5 mL** **1**	**RT** **LT**	Deltoid	IM	1/31/25			
Fluzone Tri	**0.5 mL** **1 2**	**RT** **LT**	Deltoid Vastus Lat	IM	1/31/25			
Fluzone Tri VFC	**0.5 mL** **1 2**	**RT** **LT**	Deltoid	IM	1/31/25			
Fluzone Tri 317	**0.5 mL** **1**	**RT** **LT**	Deltoid Vastus Lat	IM	1/31/25			
Flu Mist	**0.2 mL**	**Each** **Nostril**	Nasal	Nasal	1/31/25			

Signature and Title of Vaccine Administrator **Date**